Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AMERICAN HEALTH IMAGING OF DALLAS
SAN ANTONIO
BLDG 2
8627 CINNAMON CREEK
SAN ANTONIO TX 78240

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4-11-3339-01

MFDR Date Received
June 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is a designated doctor claim and should allow for payment."

Amount in Dispute: $2,225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office acknowledges that the MRI was performed due to a referral from a designated doctor for diagnostics of the shoulder. The designated doctor also acknowledges in her report that the shoulder was not being accepted b the carrier. The rules prior to 2/1/2011 allowed a carrier to perform retrospective reviews of all testing that were requested by a designated doctor. Upon completion of our review the Office maintains the denial or the diagnostic testing of a non compensable body part."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2011	73221-RT	$2,225.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 219 – Based on extent of injury
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W1 – Workers compensation state fee schedule adjustment
   - W3 – Additional payment made on appeal/reconsideration
   - * – Paid per carrier's request.

Issues

1. Did the insurance carrier issued payment for disputed CPT code 73221 pursuant to 28 Texas Administrative §134.203
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 73221-RT is $745.28. Review of the submitted documentation supports that this insurance carrier issued payment in the amount of $745.28 on April 6, 2012, warrant number 126727115, mailed to the address indicated in box 33 of the CMS-1500, AHI of Dallas, PO Box 933367, Atlanta, GA 31193-3367. As, a result, additional reimbursement cannot be recommended.
2. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT code 73221-RT.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 15, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.